MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

08379

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wisconsin
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wisconsin
City or town: Rockawalkin
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hebron Md, Rural 1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles LeRoy Atkinson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah C. Atkinson
6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): March 19, 1899

8. AGE: Years	Months	Days	If less than one day
46	4	13	...hrs. ...min.

9. Birthplace: Snow Hill Worcester Co Md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Robert J. Atkinson
13. Birthplace: Worcester Co. Md

MOTHER
14. Maiden name: Mary Elizabeth Madden
15. Birthplace: Somerset Co, Md

16. Informant: Mrs Charles R. Atkinson
Address: Hebron Md, R.D. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/4/45 (month) (day) (year)
Cemetery or crematory: Parsons cemetery
Location: Salisbury Md
18. Funeral director: The Hitch Johnson Co
Address: Salisbury, Md

19. 8/4 1945 Maggie E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 1 1945, at 11 50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1st 1945 to August 1st 1945
and that I last saw him alive on August 1st 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

20. SIGNATURE: William Emerick M. D. or other
Address: Hebron Md Date signed: Aug. 4th

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08380

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, Institution, or street address where death occurred: 103 E. Locust st
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 103 E. Locust St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lromer C. Bafford

3.(b) Social Security Number: 216-07-0938

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Lula A. Collins Bafford
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 13, 1884

8. AGE: Years	Months	Days	If less than one day
60	8	29	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Moving Picture Employee
11. Industry or business: Moving Picture Theatre
12. Name of father: Edward J. Bafford
13. Birthplace of father: Maryland
14. Maiden name of mother: Alabaster Mard
15. Birthplace of mother: Maryland
16. Informant: Mrs. L. C. Bafford
Address: Salisbury, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/14/45 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury, Md
18. Funeral director: The Hill & Johnson Co
Address: Salisbury, Md.
19. 8/14/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 11, 1945, at 10 45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Fall	
Due to: Chronic Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Floyd C. Dunlap M. D. of other
Address: Salisbury Md Date signed 8-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

(8381) Reg. Dist. No. 3-33

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsular General Hosp

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)

Street No.: Jewel (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Frank Leslie Barker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Etta D. Barker

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Nov. 6 - 1875

8. AGE: Years	Months	Days	If less than one day
69			..... hrs. ..... min.

9. Birthplace: Wilmington Del (Town, county, and state)

10. Usual occupation: Retired Clerk

11. Industry or business: Penn. Railroad Co

FATHER 12. Name: Benjamin F. Barker

FATHER 13. Birthplace: Wilmington Del

MOTHER 14. Maiden name: Sallie Nichols

MOTHER 15. Birthplace: Harrington Del

16. Informant: Mrs. F. L. Barker

Address: Delmar, Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof aug 30-1945 (month) (day) (year)

Cemetery or crematory: Hollywood

Location: Harrington Del.

18. Funeral director: H. S. Byrd Co

Address: Delmar, Del.

19. 8/28/45 (Date rec'd by registrar) Carrie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: aug 28 1945 at 2.14 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on ..... 19.....

Immediate cause of death	DURATION
Uraemia	
Haemorrhage (Cerebral)	
Due to: Nephritis	
Due to: Hypertension and arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Carrie L. Hearn M. D. or other

Address: Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8-21)

08382

CERTIFICATE OF DEATH

★ Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Don't know

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? one day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. Md
(If rural, give LOCATION)

2.(a) If veteran, name war: Don't know

3.(a) FULL NAME: Wm Britton

3.(b) Social Security Number: Don't know

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	col.	Don't know

6.(b) Name of husband or wife: Don't know

6.(c) If alive, give age: Don't know years

7. Birth date of deceased (mo., day, yr.): 1898

8. AGE: Years	Months	Days	If less than one day
about 47	—	—	....hrs. ....min.

9. Birthplace: Roanoke Va.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Peninsula General Hospital

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 14 - 1945 (month) (day) (year)

Cemetery or crematory: Public

Location: Salisbury Md

18. Funeral director: James A. Stewart

Address: Salisbury Md

19. 8/14/45 (Date rec'd by registrar) Margaret E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 7 19 45 at 5-30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....

and that I last saw h... alive on ....19....

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury: .... Injured at work?

23. SIGNATURE: Lloyd Tull M. D. or other

Address: Salisbury Md. Date signed ....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57)

CERTIFICATE OF DEATH

08383

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Allen Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Allen md

(If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME Martha Ella LO Brewington

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a.	widow

6.(b) Name of husband or wife: Joseph Brewington

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1871

8. AGE: Years	Months	Days	If less than one day
about 74	—	—	..... hrs. ..... min.

9. Birthplace: Allen md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER

12. Name: Samuel Baunds

13. Birthplace: Allen md

MOTHER

14. Maiden name: Maranda Wainwright

15. Birthplace: Quantico md

16. Informant: Mr. Lindley Young

Address: Allen Md R

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 24 - 1945 (month) (day) (year)

Cemetery or crematory: Friendship

Location: Allen md

18. Funeral director: James H. Stewart

Address: Salisbury Md

19. 8/23/45 (Date rec'd by registrar) 1945 Harriet D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-21 19 45 at 6 30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-3 19 45 to 8-21 19 45 and that I last saw h... alive on 8-17 19 45

Immediate cause of death	DURATION
Respiratory Failure	
Due to: Senility	
Due to:	
Other conditions: Hypertrophied Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E Purnell M.D. M. D. or other

Address: 100 W. Main St. Date signed: 8-23-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

08384

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:

County: Wicomico

City or town: Mardela Springs - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Near San Domingo

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Mardela Springs - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Near San Domingo

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: William J. Brown

3.(b) Social Security Number: 216-03-6224

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Amy E. Brown

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): July 15, 1890

8. AGE: Years	Months	Days	If less than one day
55	0	21	... hrs. ... min.

9. Birthplace: Wicomico County, Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER — 12. Name: William L. Brown

FATHER — 13. Birthplace: Wicomico County, Maryland

MOTHER — 14. Maiden name: Rachael A. Gaines

MOTHER — 15. Birthplace: Wicomico County, Maryland

16. Informant: Mrs. Amy E. Brown

Address: Mardela Springs, Maryland, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 9 1945 (month) (day) (year)

Cemetery or crematory: San Domingo Cemetery

Location: Near Sharptown, Maryland

18. Funeral director: J. J. Frampton and Son

Address: Federalsburg, Maryland

19. 8/9/45 (Date rec'd by registrar) 19... W. H. Stanton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 1945, at 5:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 1945, to August 4 1945, and that I last saw him alive on August 4 1945

Immediate cause of death	DURATION
Carcinoma of Bladder	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: William Emrich M. D. or other

Address: Helen, Md. Date signed: Aug 9 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

08385

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 5 Years 10 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 307 North Park Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Aaron Byrd

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: Helen Conquest Byrd

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 30, 1917

8. AGE: Years: 28 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Pastonia
(Town, county, and state)

10. Usual occupation: Finances Business

11. Industry or business: Md Finance Credit Corp.

MOTHER FATHER

12. Name: Aaron Byrd

13. Birthplace: Pastong / Sa

14. Maiden name: Edith Maybelle Moore

15. Birthplace: Wilmington, Del.

16. Informant: Aaron Byrd Jr.

Address: Parksley, Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 3 1945 (month) (day) (year)

Cemetery or crematory: Greenwood

Location: Temperanceville, Va.

18. Funeral director: J. D. Johnson, Inc.

Address: Parksley, Va.

19. 8/31/45 (Date rec'd by registrar) Carrie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 31 1945, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 30 1945 to Aug 31 1945 and that I last saw him alive on Aug. 31 1945

Immediate cause of death	DURATION
Diabetic Acidosis	
Due to: Diabetes Mellitus	
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: none Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Linus Hansen M.D.
M. D. or other

Address: Salisbury Md Date signed: 8-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08386

Reg. Dist. No. 393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 2 years

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: md County: Wicomico

City or town: Salisbury R.F.D. #2

(If outside city or town limits, write RURAL and give nearest town)

Street No.: no

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME Elmer Cannon

3. (b) Social Security Number 220-01-8481

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	married

6.(b) Name of husband or wife: Pinky Cannon

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): June 1, 1912

8. AGE:

Years	Months	Days	If less than one day
33	2	28	..... hrs. ..... min.

9. Birthplace: Princess Anne md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER 12. Name: Lit Cannon

FATHER 13. Birthplace: Princess Anne md

MOTHER 14. Maiden name: Millie Waters

MOTHER 15. Birthplace: Princess Anne md

16. Informant: Mrs. Millie Cannon

Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 2-1945 (month) (day) (year)

Cemetery or crematory: St mary

Location: West Post Office md

18. Funeral director: James F. Stewart

Address: Salisbury md

19. 9/1 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 29. 1945; at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1945, to Aug 29 1945

and that I last saw h... alive on Aug 29 1945

Immediate cause of death	DURATION
(a) Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Geo E Lewis M. D. or other

Address: Salisbury md Date signed: 8/31/45

Dr. Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

08387

Reg. Dist. No. 333

1. PLACE OF DEATH. Wicomico

County

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, institution, or street address where death occurred: P. H. Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 809 E. Church St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lillie A. Coulbourn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Peter A. Coulbourn

6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Aug 21-1874

8. AGE: Years	Months	Days	If less than one day
71	0	1	hrs. min.

9. Birthplace RD. Parsonsburg Md. (Town, county, and state)

10. Usual occupation Home wife

11. Industry or business at Home

MOTHER FATHER

12. Name Minos Hammond

13. Birthplace RD. Parsonsburg Md.

MOTHER

14. Maiden name Mahalia Wyatt

15. Birthplace Md

16. Informant Miss Carrie Coulbourn

Address 809 E. Church St. Salisbury Md

17. Burial Date thereof Aug 24-45 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parsons Cem.

Location Salisbury Maryland

18. Funeral director Holloway & Walter R Holloway

Address Salisbury Maryland

19. 8/24/45 (Date rec'd by registrar) 1945 Harriet E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22nd 1945 at 10 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935, to Aug 22 1945

and that I last saw her alive on Aug 22 1945

Immediate cause of death	DURATION
Diabetes Mellitus	Over 10 yrs
Due to	
Due to	
Other conditions Carbuncle of Vulva	2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hiram R Mann M. D. or other

Address Salisbury Md Date signed 8-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

08388

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 Months

Hospital, institution, or street address where death occurred: 415 Dana St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Maddela Springs (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Anna Darby

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow

6.(b) Name of husband or wife: Job Darby

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 31, 1860

8. AGE: Years: 85 Months: 2 Days: 3 If less than one day: hrs. min.

9. Birthplace: Maddela Wicomico, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: William Phillips

FATHER — 13. Birthplace: Maddela Md.

MOTHER — 14. Maiden name: Matilda Lecken

MOTHER — 15. Birthplace: Maddela Md.

16. Informant: Walter Darby

Address: Maddela Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/5/45 (month) (day) (year)

Cemetery or crematory: Maddela Cemetery

Location: Maddela, Md.

18. Funeral director: David A. Messick

Address: Hebron, Md.

19. 8/6 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3, 1945, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1945 to June 26 1945 and that I last saw h.. alive on June 26 1945

Immediate cause of death	DURATION
Cardiac failure	
Due to: Coronary heart disease	
Due to: —	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D. Allen Fields / Stuart C. Finch M.D. M. D. or other

Address: Salisbury, Md. Date signed: 8/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

★ 08389 Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Wicomico
County
City or town Parsonsburg. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 da.
Hospital, Institution or street address where death occurred: RD. #1.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Wicomico
City or town Parsonsburg. (If outside city or town limits, write RURAL and give nearest town)
Street No. RD. #1. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Maurice Robert Davis
3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced
6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug. 14 1945
8. AGE: Years | Months | Days: 6 | If less than one day ..... hrs. ..... min.
9. Birthplace: RD. #1. Parsonsburg Md (Town, county, and state)
10. Usual occupation
11. Industry or business
12. FATHER Name: Carlton Henry Davis
13. FATHER Birthplace: Parsonsburg Md
14. MOTHER Maiden name: Bernice Mae Brown
15. MOTHER Birthplace: RD. #1. Parsonsburg Md
16. Informant: Mr. Carlton H. Davis
Address: RD. #1. Parsonsburg. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 21-45 (month) (day) (year)
Cemetery or crematory: Bethel Church Cem.
Location: Walston Maryland
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md
19. 8/21 1945 (Date rec'd by registrar) Lillian L. Davis Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 20th 1945 at 1 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from day of birth to day of death 19 ..... and that I last saw him alive on day of death Aug 20 45 19 .....

	DURATION
Immediate cause of death: Premature birth (5 1/2 months)	
Unable to nurse, died from	
Due to: lack of food and water	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank C. Lewis M.D. M. D. or other
Address: Mardela Md. Date signed 8-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 08394 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Delmar, Del. & Rural (Md.)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Hebron
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME: Mary J. Dickerson

3. (b) Social Security Number:

4. Sex: F.
5. Color or race: Col'd
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Oliver Dickerson
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 22, 1883
8. AGE: Years: 62 Months: 9 Days: 19 If less than one day: hrs. min.
9. Birthplace: Salisbury, Wicomico, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Isaac Burris
13. Birthplace: Salisbury Md.
MOTHER 14. Maiden name: Unknown
15. Birthplace:
16. Informant: Clifton Dickerson
Address: Hebron, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/6/45 (month) (day) (year)
Cemetery or crematory: Mardela Cemetery
Location: Mardela, Md.
18. Funeral director: David E. Roesdick
Address: Hebron, Md.
19. Aug 4 1945 Wm. G. Mann
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3, 1945 at 1 1. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1945 to Aug 3 1945
and that I last saw h[illegible] alive on August 2d 1945

Immediate cause of death	DURATION
Chronic Nephritis	
Due to	
Due to	
Other conditions Chronic Myocarditis	

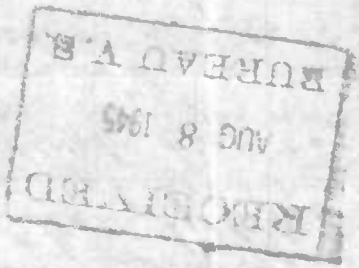
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William Emrich M. D. or Other
Address: Hebron Md. Date signed: Aug. 6th 45

Mr Mesarch could not get the Dr
information until the 8/6/45 as the
Dr was away.
Why two dates.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (R3)

CERTIFICATE OF DEATH

08391

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town White Haven Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Route #2 Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Dyres Drew

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1944

8. AGE: Years	Months	Days	If less than one day
1	6	14	____ hrs. ____ min.

9. Birthplace Salesbury Md. (Town, county, and state)

10. Usual occupation

11. Industry or business —

FATHER 12. Name George Drew

13. Birthplace Mt Vernon, Md.

MOTHER 14. Maiden name Margaret Drew

15. Birthplace Metuchen, N. J.

16. Informant Mrs Margaret Drew

Address Mt Vernon, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 31, 1945 (month) (day) (year)

Cemetery or crematory Episcopal Cemetery

Location Princess Anne, Md.

18. Funeral director Wade Waehill

Address Princess Anne, Md.

19. 8/31/1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1945, at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to Aug. 30 1945

and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Accidental Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Aug 29 or 30

Where did injury occur? White Haven Wicomico Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jno. D. Grant M.D. Deputy Medical Examiner Wicomico County

M. D. or Coroner

Address Salisbury Md Date signed 8/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08392 336

1. PLACE OF DEATH:

County: Wicomico

City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 weeks

Hospital, Institution, or street address where death occurred: 206 Pine Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Hebron (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Miranda Elizabeth Dunn

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Leonard H. Dunn

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): Jan 26 - 1864

8. AGE: Years: 81 Months: Days: If less than one day: hrs. min.

9. Birthplace: Sussex County, Del. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER — 12. Name: Samuel Kinney

FATHER — 13. Birthplace: Sussex County, Del.

MOTHER — 14. Maiden name: Julia Kinney

MOTHER — 15. Birthplace: Sussex County, Del.

16. Informant: Mrs Allen Robbins

Address: Delmar, Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 1-1945 (month) (day) (year)

Cemetery or crematory: Ralph Hill

Location: Delmar, Del R 2 D

18. Funeral director: W. S. Lynch Co

Address: Delmar, Del.

19. 9-1-1945 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 29 1945 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1944, to Aug 29 1945

and that I last saw her alive on Aug 29 1945

	DURATION
Immediate cause of death: Intestinal obstruction	2 hours
due to: Carcinoma of Stomach	3 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Lynch M. D. or other

Address: Delmar Del Date signed: Aug 31/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (302)

08393

CERTIFICATE OF DEATH

Reg. Dist. No. 11336

1. PLACE OF DEATH:

County Wicomico

City or town Delmar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years.

Hospital, Institution, or street address where death occurred:

3 East Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State Maryland County Wicomico

City or town Delmar

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 East Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie Louisa Elliott

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Jos. J. Elliott

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 16 1876

8. AGE: Years	Months	Days	If less than one day
68			..... hrs. ..... min.

9. Birthplace Delmar, Del. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name Burton Elliott

FATHER 13. Birthplace Delaware

MOTHER 14. Maiden name Elizabeth Ellen Horn

MOTHER 15. Birthplace Delaware

16. Informant Elizabeth Elliott

Address Delmar, Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 2 - 45 (month) (day) (year)

Cemetery or crematory Holy Cross Cemetery

Location Delmar, Del.

18. Funeral director J. E. Bynard Co

Address Delmar, Delaware

19. 9-1- 1945 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1945, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 30 1945, to Aug 30 1945 and that I last saw h.. alive on Aug 30 1945

Immediate cause of death	DURATION
Abdominal Hemorrhage	1 minute
Due to Laceration of abdominal Aorta	Probably 2 hrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Lynch M. D. or other

Address Delmar, Del. Date signed Aug 31 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-d

CERTIFICATE OF DEATH

08394

Reg. Dist. No. 333

1. PLACE OF DEATH: County Wicomico; City or town near Delmar (If outside city or town limits, write RURAL and give nearest town); How long in above place of death? 32 years; Hospital, Institution or street address where death occurred: P.O. RD.#3. Delmar Del.; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED! (For newborn infants give residence of mother) State Md. County Wicomico; City or town near Delmar (If outside city or town limits, write RURAL nnd give nearest town); Street No. RD. #3 Delmar Del. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Wesley Elliott

3. (b) Social Security Number

4. Sex: Male | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Bertha E. Elliot; 6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Sept. 16-1872

8. AGE: Years: 72 | Months: 11 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Own Farm

FATHER — 12. Name: John Wesley Elliott

13. Birthplace: Princess Anne Md

MOTHER — 14. Maiden name: Ellen Sarah Bumpley

15. Birthplace: P.O. Princess Anne Md.

16. Informant: Mrs. Bertha E. Elliot; Address: RD.#3 Delmar Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 1 1945 (month) (day) (year)

Cemetery or crematory: Parsons Am.; Location: Salisbury Maryland

18. Funeral director: Tolbert & Co. Walter R. Tolbert; Address: Salisbury Md.

19. 9/1/45 (Date rec'd by registrar) Hassie E. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1945 at 2.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 25 1945 to Aug 30 1945 and that I last saw him alive on Aug 29 1945

Immediate cause of death	DURATION
Valvular Heart Disease	Years
Due to	
Due to	
Other conditions Pleurisy	10 days

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE Thos R Mann M. D. or other

Address Salisbury Md. Date signed 8/31/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08395

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mos
Hospital, institution or street address where death occurred: R.D. #1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #1.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clarissa Jane Ennis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles Edward Ennis
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): April 17-1865

8. AGE:

Years	Months	Days	If less than one day
80	3	15	hrs. min.

9. Birthplace: Worcester Co. Md.
(Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: at Home
12. FATHER — Name: Lambert Ennis
13. FATHER — Birthplace: Dead Island Md.
14. MOTHER — Maiden name: —
15. MOTHER — Birthplace: —
16. Informant: Mr. Roy W. Ennis
Address: Fruitland Maryland
17. Buried — Date thereof: Aug 5-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Ennis Cem
Location: Worcester Co. Md.
18. Funeral director: Hellings & Walter R. Hellings
Address: Salisbury Md.
19. 8/15/1945 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 2nd 1945 at 3 P M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Aug 1 1945 to Aug 2 1945, and that I last saw h[illegible] alive on Aug 2 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	sudden death
Due to	
Due to	
Other conditions: No	

(Include pregnancy within 3 months of death)

Major findings of operations: No
Date of op.
Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. P. Redington MD
Deputy Med. Examiner
M. D. or other
Address: Salisbury Md. Date signed: 8/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

(1)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08396

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution or street address where death occurred: P. G. Hoyt
How long in hospital or institution? 7 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 107 Germane St. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ralph Edward Ennis Jr.
3. (b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Aug. 3rd 1945
8. AGE: Years | Months | Days 9 | If less than one day ... hrs. ... min.
9. Birthplace P. G. Hoyt, Salisbury Md. (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name Ralph Edward Ennis
13. Birthplace R.D. #2 Delmar Delaware
MOTHER 14. Maiden name Gertrude Evelyn Martz
15. Birthplace Hastings Michigan
16. Informant Ralph E. Ennis
Address 107 Germaine St. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 13-45 (month) (day) (year)
Cemetery or crematory Parsons Cemetery
Location Salisbury Maryland
18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Md.
19. 8/13, 19 45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12th 19 45, at 2 20 am
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-3-45 19 , to 8-12 19 45
and that I last saw him alive on 8-12-45 19

Immediate cause of death (1) Haemorrhagic jaundice
(2) Shock
Due to
Due to
Other conditions Prematurity & underweight (Include pregnancy within 3 months of death)
DURATION

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE C. J. Hearn M.D. or other
Address ... Date signed 8/13/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

CERTIFICATE OF DEATH

08397

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, institution, or street address where death occurred: P. H. Hoyt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1006 E. Church St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Woodland Samuel Fields

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Minnie C. Fields
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Dec. 24 - 1879

8. AGE:

Years	Months	Days	If less than one day
65	8	3	... hrs. ... min.

9. Birthplace: Shad Point Md
(Town, county, and state)
10. Usual occupation: Worker
11. Industry or business: at Mint Factory
FATHER 12. Name: Dan'l Fields
13. Birthplace: Shad Point Md.
MOTHER 14. Maiden name: Alvesta Smith
15. Birthplace: Shad Point Md.
16. Informant: Mrs. Ethel Bergman
Address: 1006 E. Church St. Salisbury Md
17. Burial (Burial, cremation, or removal? Which?) Date thereof: Aug. 29-'45 (month) (day) (year)
Cemetery or crematory: Parsons Mem.
Location: Salisbury Md
18. Funeral director: Hellen & C. Walter R. Holloway
Address: Salisbury Md
19. 8/29/1945 (Date rec'd by registrar) Lizzie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 27 - 45 at 2.15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 11, 19 45, to Aug. 27, 19 45, and that I last saw him alive on Aug. 26, 19 45

Immediate cause of death	DURATION
Pericarditis & Myocarditis	
Due to Acute pericarditis Duration: 2 months	
Chronic myocarditis Duration: 2 years	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.: ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?
23. SIGNATURE: Jno. D. Gray (Asst.) M. D. or other
Address: Salisbury Md. Date signed: 8/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

[redacted] G98 OCT 29 1945

08398

Reg. Dist. No. 933

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: na
How long in hospital or institution? na

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. na
(If rural, give LOCATION)
2.(a) If veteran, name war: na

3.(a) FULL NAME: William Lloyd Finney

3.(b) Social Security Number: na

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	Single

6.(b) Name of husband or wife: no
6.(c) If alive, give age: na years

7. Birth date of deceased (mo., day, yr.): Nov. 16 1929

8. AGE: Years	Months	Days	If less than one day
15			hrs. min.

9. Birthplace: Salisbury and (Town, county, and state)
10. Usual occupation: School Boy
11. Indusfry or business: no

FATHER
12. Name: William L. Finney
13. Birthplace: Somerset Co

MOTHER
14. Maiden name: Mary L. Finney
15. Birthplace: Salisbury Md

16. Informant: Mrs Mary L. Dennison
Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 16 1946 (month) (day) (year)
Cemetery or crematory: Hasslton
Location: Salisbury Md

18. Funeral director: James T. Stewart
Address: Salisbury Md

19. 8/14 19 45 H. Harriet Co (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/13 19 45 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to 8/13 19 45
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Accidental drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operatioos: none ... Date of op. ...
Autopsy results: none
PHYSICIAN: Please nnderline the cause to which death shoold be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 8/13/45
Where did injury occur? Salisbury (City or town) Wicomico (County) Md. (State)
Injured at home, farm, industry, public place (where?) Outlet Pole
Means of injury Accidental drowning Injured at work?

23. SIGNATURE: H. River Hanson, M.D.
M. D. or other
Address: Salisbury Md. Date signed 8/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73)

CERTIFICATE OF DEATH

08399

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Somerset

City or town: Princess Anne
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R F D #3
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Sandra L. Fitzsimmons

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 6, 1945

8. AGE: Years | Months | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Salisbury, Md.
(Town, county and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Henry A. Fitzsimmons
13. Birthplace: Grand Rapids, Michigan

MOTHER
14. Maiden name: Doris Neal
15. Birthplace: Staten Island, N.Y.

16. Informant: Mrs. Neal
Address: Allen, Md.

17. Burial, cremation, or removal. Which? Burial Date thereof: Aug. 13, 1945 (month) (day) (year)
Cemetery or crematory: John Wesley Cemetery
Location: Mt. Vernon, Md.

18. Funeral director: Dale Washell
Address: Princess Anne, Md.

19. 8/13/45 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 11, 1945, at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 6, 1945, to Aug. 11, 1945 and that I last saw h.. alive on Aug. 11, 1945

	DURATION
Immediate cause of death: Acute Hemolytic Anemia of Newborn	
Due to: RH Syndrome	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. Powers Hanson, M.D.
M. D. or other

Address: Salisbury, Md. Date signed: 8/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Gray

(M)

084[illegible]0

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, institution, or street address where death occurred: P.G. Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 310 Martin St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sarah Emma Haddock

3.(b) Social Security Number

4. Sex: female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Larry Thomas Haddock
6.(c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.): April 27-1873

8. AGE: Years	Months	Days	If less than one day
72	4	3	....hrs. ....min.

9. Birthplace: W.O. Berlin Md.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: at Home
FATHER
12. Name: William J. Jones
13. Birthplace: Worcester Co. Md.
MOTHER
14. Maiden name: Mary Ann Coffin
15. Birthplace: Worcester Co. Md.
16. Informant: Mr. Larry T. Haddock
Address: 310 Martin St. Salisbury Md.
17. Burial — Date thereof: Sept. 1 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.
19. 9/1 1945 Harriet J. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30th 1945, at 10 45 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1945, to Aug. 30 1945
and that I last saw her alive on Aug. 30 1945

Immediate cause of death	DURATION
Arteriosclerotic Cardiovascular Renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Salisbury Md.
Date signed 8/31/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08401

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 Weeks
Hospital, institution, or street address where death occurred: Penn. Penn. Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME Emma D. Hales

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Frederick Hales
6.(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): Oct 11 - 1867

8. AGE: Years: 77 Months: 9 Days: 26 If less than one day: hrs. min.

9. Birthplace: Snow Hill Worcester Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Emily Kennedy
15. Birthplace: Maryland

16. Informant: Mrs Charles Bowen
Address: 1705 E Division St Salisbury Md

17. Burial, cremation, or removal. Which?: Burial Date thereof: Aug 9 45 (month) (day) (year)
Cemetery or crematory: Whatcoat
Location: Snow Hill, Md
16. Funeral director: Deane & Timms
Address: Snow Hill, Md

19. (Date rec'd by registrar): 8/8/45 - Harold E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 19 45 at 10.40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Fractured hip	11 weeks.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Aug 6 45
Where did injury occur? Snow Hill (City or town) Worcester (County) Md (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: Fall in home Injured at work? No

23. SIGNATURE: John L. Riley M. D. or other
Address: Snow Hill Md Date signed: 8/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

08402

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, institution, or street address where death occurred: P.S. Hazel.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother.)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 700½ E. Vine St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Zackariah Washington Hill

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Nettie M. Hill
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): April 29-1872

8. AGE: Years	Months	Days	If less than one day
73	3	22	...hrs. ...min.

9. Birthplace: R.D. Georgetown Del.
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:
12. Name of father: Columbus Hill
13. Birthplace of father: R.D. Laurel, Del
14. Maiden name of mother: Elizabeth Deates
15. Birthplace of mother: Laurel Del
16. Informant: Mr. George W. Hill
Address: 700½ E. Vine St. Salisbury Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug 24-1945 (month) (day) (year)
Cemetery or crematory: Parsons Mem.
Location: Salisbury Maryland
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland.
19. 8/24/1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 21st 1945 at 11:20 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to Aug 21 1945
and that I last saw him alive on Aug 21 1945

Immediate cause of death	DURATION
(a) Cor. Pulmonale	
Due to	
Due to	
Other conditions: Chr. Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. SIGNATURE: Rudolph A. Leonard M. D. or other
Address: Dal. Quarry Md Date signed: 8/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

08403

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke
(If outside city or town limits, write RURAL and give near

Street No.: Laurel
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mr. Alonza Holland.

3.(b) Social Security

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	married

B.(b) Name of husband or wife: Mrs. Mamie Holland

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): October 18, 1880

8. AGE:

Years	Months	Days	If less than one day
64	10	0	hrs. min.

9. Birthplace: Pocomoke city, Worcester, Md
(Town, county, and state)

10. Usual occupation: Lumber dealer

11. Industry or business

FATHER — 12. Name: Ira Frank Holland

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Bertie Duncan

MOTHER — 15. Birthplace: Md

18. Informant: Mamie E. Holland

Address: Pocomoke city, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 20, 1945 (month) (day) (year)

Cemetery or crematory: Hasa Hill

Location: Pocomoke city

18. Funeral director: Margarette H Watson

Address: Pocomoke city, Md.

19. 8/20/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18, 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deced

Aug 16 1945, to

and that I last saw h alive on aug 18 1945

Immediate cause of death: Virus Pneumonia.
Bilateral, Bronchial

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County)

Injured at home, farm, industry, public place (which?)

Means of injury Injured at work?

23. SIGNATURE: J. A. Robinson MD M. D.

Address: Salisbury Md 8/15/45 Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1357)

CERTIFICATE OF DEATH

18404

★ Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 Days
Hospital, Institution, or street address where death occurred: P.H. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No ✓

3.(a) FULL NAME: Willie Holland

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(d) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 17/45

8. AGE: Years: — Months: 4 Days: — If less than one day: ..... hrs. ..... min.

9. Birthplace: Snow Hill, Worcester, Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business:

FATHER
12. Name: Dennis Holland
13. Birthplace: Maryland

MOTHER
14. Maiden name: Addie Gillis
15. Birthplace: Maryland

18. Informant: Dennis Holland
Address: Snow Hill, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 17/45 (month) (day) (year)
Cemetery or crematory: Baptist
Location: Snow Hill, Md.

18. Funeral director: Deane & Dennis
Address: Snow Hill, Md.

19. 8/17/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 19 45, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/3/45 19 to 8/17/45 19 and that I last saw h.. alive on 8/.3/45 19

Immediate cause of death	DURATION
Peri-nephritic Abscess	2 wks.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Perinephritic abscess
Date of op. 8/.6/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Paul Owen M.D
M. D. or other
Address: Snow Hill Date signed 8/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08405

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
P. L. Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Lakeside Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harry L. Jones

3.(b) Social Security Number: 214-03-1472

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Minnie A. Jones
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Aug. 16, 1895

8. AGE:

Years	Months	Days	If less than one day
49	11	27	...hrs. ...min.

9. Birthplace: Quantico, Wicomico Co., Md. (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business: Building Materials
FATHER 12. Name: Albert L. Jones
13. Birthplace: Wicomico Co. Md.
MOTHER 14. Maiden name: Mary Crawford
15. Birthplace: Wicomico Co. Md.
16. Informant: Mrs. Harry L. Jones
Address: Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/15/45 (month) (day) (year)
Cemetery or crematory: Episcopal cemetery
Location: Quantico, Md.
18. Funeral director: The Hall & Johnson Co.
Address: Salisbury, Md.
19. 8/14/45 (Date rec'd by registrar) Carrie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 13th 1945 at 1:55 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 10 1945 to Aug. 13 1945 and that I last saw h.i.m. alive on Aug. 13 1945

Immediate cause of death	DURATION
CORONARY Occlusion, Acute	
Due to: CORONARY SCLEROSIS	
Due to:	
Other conditions: Auricular Fibrillation	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. Rivers Hanson, M.D.
M. D. or other
Address: Salisbury, Md. Date signed 8/13/45

08406

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 999

1. PLACE OF DEATH:
County: Wilomico
City or town: Salisbury Md R.F.D. No 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? One day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury Md R.F.D. No 1
(If outside city or town limits, write RURAL and give nearest town)
Street No. no
(If rural, give LOCATION)
2.(a) If veteran, name war: non

3.(a) FULL NAME: William Douglas Jones

3.(b) Social Security Number: Can't be found

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a a	Married

6.(b) Name of husband or wife: Louise James
6.(c) If alive, give age: yes 28 years
7. Birth date of deceased (mo., day, yr.): about 1939

8. AGE: Years: 16 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Allen Md (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Same as above
FATHER 12. Name: Marion James
FATHER 13. Birthplace: Quantico
MOTHER 14. Maiden name: Ella Bounds
MOTHER 15. Birthplace: Allen md
16. Informant: Mrs. Louise Jones
Address: Salisbury R.F.D. No 1
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 17 - 1945 (month) (day) (year)
Cemetery or crematory: Friendship
Location: Allen Md
18. Funeral director: James D. Stewart
Address: Salisbury Md
19. 8/14/1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-13 19 45 at 5 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Left Hemothorax	8 hours
Punctured Lung	
Due to Fractured 7-10 Ribs Left	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: non
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: assault Date of 8/12/45
Where did injury occur? near Salisbury Wicomico Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Highway
Means of injury: Drove car into ditch Injured at work? No

23. SIGNATURE: J. Hollademyer M. D.
Address: Salisbury Md Date signed 8/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

(18417)

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:
County: Wicomico
City or town: Westfield (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: na
How long in hospital or institution? na

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Westfield md (If outside city or town limits, write RURAL and give nearest town)
Street No. na (If rural, give LOCATION)
2.(a) If veteran, name war: na

3. (a) FULL NAME: Leven D Lankford

3. (b) Social Security Number: na

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	Widower

6.(b) Name of husband or wife: Mary L. Lankford
Dead 6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): about 1888

8. AGE: Years: about 57 | Months: — | Days: — | If less than one day: ... hrs. ... min.

9. Birthplace: Westfield Md (town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER
12. Name: Arnold Lankford
13. Birthplace: Westfield md

MOTHER
14. Maiden name: Mary A. Wright
15. Birthplace: Westfield Md

16. Informant: Asbury Lankford
Address: Westfield md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 10 1945 (month) (day) (year)
Cemetery or crematory: Odd Fellows
Location: Westfield md

18. Funeral director: James F. Stewart
Address: Salisbury Md

19. Aug. 10, 1945 (Date rec'd by registrar) R. Woolford Walter per SDB Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-6 1945, at 8:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-30 1945, to 8-6 1945; and that I last saw h. alive on 7-31 1945

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Acute dilation	
Due to: Myocardial damage	
Arteriosclerosis	
Other conditions: Nephritis, chronic interstitial	
Duration undetermined Cause	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E A. Purnell M.D. (M. D. or other)
Address: 800 W. Main St. Date signed: 8-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

08408

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred: Wicomico Farm
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infant give residence of mother)
State Md. County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. RD. #2 (Cycling Hill Road) (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Herman Layfield — 3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Iris Webster Layfield — 6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): March 1st 1912

8. AGE: Years	Months	Days	If less than one day
33	5	14	hrs. min.

9. Birthplace: Salisbury Maryland (Town, county, and state)
10. Usual occupation: Privat First Class
11. Industry or business: U. S. Army
12. FATHER Name: John Henry Layfield
13. FATHER Birthplace: Deal Island Md.
14. MOTHER Maiden name: Nettie C. Webster
15. MOTHER Birthplace: Deal Island Md.
16. Informant: Mrs. Iris Webster Layfield
Address: RD. #2. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 18-45 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Maryland
18. Funeral director: Wallace & Walter R. Wallace
Address: Salisbury Maryland.
19. 8/18/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 15th 1945 at 2:45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I (last) saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Drowning	Instantaneous
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 8/15/45
Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)
Injured at home, farm, industry, public place (where?) River
Means of injury Went in swimming Injured at work? No
Seized w cramps.
23. SIGNATURE: Jo Rademaker MD M. D. or other
Address: Salisbury Md Date signed 8/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-F)

CERTIFICATE OF DEATH

Reg. Dist. No. 4 — 18419 — 336

1. PLACE OF DEATH:
County: Wicomico
City or town: Delmar (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: R.F.D. # 3
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 36 years.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Delmar (If outside city or town limits, write RURAL NEAR and give town) Ward No.
Street No.: R F D # 3 (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Hezekiah Stanton Towe

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Ellen Towe
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): June 20 1867

8. AGE: Years: 78 Months: Days: If less than one day: hrs. min.

9. Birthplace: Laurel, Del. (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business: Farm
FATHER 12. Name: Selby Towe
FATHER 13. Birthplace: Delaware
MOTHER 14. Maiden name: Leah McAllister
MOTHER 15. Birthplace: Delaware
16. Informant: Paul R. Towe
Address: Delmar, Del.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 8 1945 (month) (day) (year)
Cemetery or crematory: M. E.
Location: Delmar, Delaware
18. Funeral director: M. S. Mumford Co
Address: Delmar, Del.
19. 8/8/45 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 6 1945, at 3 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to Aug 6 1945 and that I last saw h[illegible] alive on Aug 6 1945.

Immediate cause of death	DURATION
Prime Cause	2 hr
Due to Cardiac Asthma & Hyp -	10 yr
Due to Chronic Nephritis	3 yr.
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J H Fond M. D. or other
Address: Delmar Del Date signed 8/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08410

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 11336

1. PLACE OF DEATH:

County Wicomico

City or town Delmar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years.

Hospital, Institution, or street address where death occurred:

10 Pine Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 Pine

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joshua Jerome Morris

3.(b) Social Security Number 716-03-1563

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Addie Morris

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 16 - 1878

8. AGE: Years 67 Months Days If less than one day ..... hrs. ..... min.

9. Birthplace Snow Hill, Md.

(Town, county, and state)

10. Usual occupation Retired Conductor

11. Industry or business Penn. Railroad Co.

FATHER 12. Name Joshua Jerome Morris

FATHER 13. Birthplace Snow Hill, Md.

MOTHER 14. Maiden name Priscilla Godfrey

MOTHER 15. Birthplace Snow Hill, Md.

16. Informant Mrs J. J. Morris

Address Delmar, Del.

17. Burial (Burial, cremation, or removal, which?) Date thereof Sept 1-1945 (month) (day) (year)

Cemetery or ~~crematory~~ Parsons

Location Salisbury, Maryland

18. Funeral director G. S. Frank Co.

Address Delmar, Delaware

19. 9-1-1945 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1945 at 2 1 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 29 1945, to Aug 29 1945 and that I last saw h.im alive on Aug 29 1945

	DURATION
Immediate cause of death Acute coronary thrombosis	2 hours
Due to Arteriosclerosis	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. H. Hazel M. D. or other

Address Delmar, Del. Date signed Aug 31 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08411

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 260333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Hospital

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Salisbury Pen. Gen.

How long in hospital or institution? 1 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Somerset

City or town E. Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Lucinda R. mullen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	

6.(b) Name of husband or wife [illegible] Green

6.(c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1946

8. AGE: Years | Months 6 | Days | If less than one day ... hrs. ... min.

9. Birthplace Princess Anne Somerset md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business "

FATHER 12. Name William Green

FATHER 13. Birthplace norfolk va.

MOTHER 14. Maiden name Cheane mullen

MOTHER 15. Birthplace Keller, Va.

16. Informant Mary Sutton

Address Princess anne, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 18 45 (month) (day) (year)

Cemetery or crematory Baptist cemetery

Location west Princess anne

18. Funeral director James D. Dennis

Address Princess anne, md.

August 18, 19 45 R. T. Johnson, M.D. (Date rec'd by registrar) Registrar

Per F.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1945 at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 16 1945 to Aug 16 1945 and that I last saw h[illegible] alive on Aug 16 1945

Immediate cause of death	DURATION
Pneumonia	1 wk
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

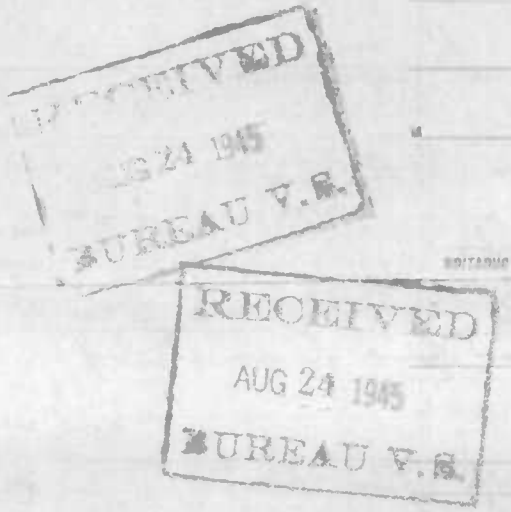
23. SIGNATURE W. Brummer M.D. M. D. or other

Address Salisbury Date signed Aug 17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

08412

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, Institution or street address where death occurred: P.H. Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 420 Oak Hill Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Marion Nitlett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie Nitlett

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 13- 1913

8. AGE: Years	Months	Days	If less than one day
32	3	25	hrs. min.

9. Birthplace: Salisbury Md. (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business

FATHER — 12. Name: John W. Nitlett

FATHER — 13. Birthplace: Whaleyville Md.

MOTHER — 14. Maiden name: Sarah Downing

MOTHER — 15. Birthplace: Whaleyville Md.

16. Informant: Mrs. Sarah ~~Nitlett~~ Nitlett

Address: 420 Oak Hill Ave. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 10-45 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury Md

18. Funeral director: Williams & Walter R. Williams

Address: Salisbury Md.

19. 8/10/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 8 19 45 at 12 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1 19 45 to Aug. 8 19 45

and that I last saw him alive on Aug. 8 19 45

Immediate cause of death	DURATION
Valvular Heart Disease	weeks
Due to	
Due to	
Other conditions: Chronic Nephritis	weeks

(Incinde pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please noderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos R Mann M. D. or other

Address: Salisbury, Md. Date signed: 8/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Mann

08413

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 41 years
Hospital institution, or street address where death occured: 103 Cherry Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. Walston Lane (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mutter John Parker
3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Widower
6.(b) Name of husband or wife Lucy Shockley Parker
6.(c) If alive, give age Dead years
7. Birth date of deceased (mo., day, yr.) Sept. 18 - 1872

8. AGE: Years	Months	Days	If less than one day
72	11	7	hrs. min.

9. Birthplace R.D. Parsonsburg Md. (Town, county, and state)
10. Usual occupation Saw Filler
11. Industry or business at Lumber Mill
FATHER 12. Name Joshua J. Parker
13. Birthplace R.D. Parsonsburg Md.
MOTHER 14. Maiden name Adeline Workman
15. Birthplace R.D. Parsonsburg Md
16. Informant Mrs. Mildred Dotterhann
Address 3011 West St. Wilmington Del
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 28-45 (month) (day) (year)
Cemetery or crematory Wicomico Mem. Park
Location Salisbury Md
18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Md
19. 8/28, 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25th 1945, at 11:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to Aug. 25 1945
and that I last saw him alive on Aug. 22 1945

	DURATION
Immediate cause of death Cerebral Hemorrhage (2nd Hemorrhage)	10 days
Due to Hypertension	[illegible]
Due to	
Other conditions Chronic Nephritis	2 yrs

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Hume R Mann M. D. or other
Address Salisbury Md Date signed 8/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

018414

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo 23 days

Hospital, institution, or street address where death occurred:

E.S. Nr Bancstown

How long in hospital or institution? 2 mo 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 560 Jackson St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Arthur Thomas Phipps

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Rosa A Phipps

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Nov 18 1887

8. AGE: Years: 57 Months: 9 Days: 6 If less than one day: ..... hrs. ..... min.

9. Birthplace: Salisbury Wicomico Co Maryland

(Town, county, and state)

10. Usual occupation: Blacksmith

11. Industry or business:

FATHER

12. Name: Wm J. Phipps

13. Birthplace: Salisbury Maryland

MOTHER

14. Maiden name: Mary Jones

15. Birthplace: Delton Maryland

16. Informant: deceased on admission

Address: —

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug. 27-45 (month) (day) (year)

Cemetery or crematory: Parsons Plan

Location: Salisbury Md.

18. Funeral director: Hillman & Co. Walter R. Hillman

Address: Salisbury Md.

19. 8/25/45 (Date rec'd by registrar) Lassie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 1945, at 12:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to Aug 24 1945

and that I last saw h— alive on 8/24/45 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Paul Cohen M.D. M. D. or other

Address: Salisbury Date signed: 8-25-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

CERTIFICATE OF DEATH

08415

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Worcester

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Berlin R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME Emerson Purnell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col'd	Married

6.(b) Name of husband or wife: Annie E Purnell

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): about 1899

8. AGE: Years	Months	Days	If less than one day
about 46			....hrs. ....min.

9. Birthplace: Berlin Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER 12. Name: William Purnell

13. Birthplace: Berlin md

MOTHER 14. Maiden name: Elizabeth Massey

15. Birthplace: Berlin md

16. Informant: Annie Purnell

Address: Berlin md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 9 - 1945 (month) (day) (year)

Cemetery or crematory: Family

Location: Berlin Md

18. Funeral director: Jarrett L. Stewart

Address: Salisbury Md

19. 8/8/45 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 4 1945, at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19.... to .... 19....

and that I last saw h.... alive on .... 19....

Immediate cause of death	DURATION
Bled to death from knife wounds	2 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .... Date of op. ....

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of: Aug 4 '45

Where did injury occur? Ocean City (City or town) Worcester (County) Md (State)

Injured at home, farm, industry, public place (where?): On the Street

Means of injury: Cut by Knife Injured at work? No

23. SIGNATURE: John L. Perry Dep. Med. Exam. M. D. or other

Address: Snow Hill Md Date signed: Aug 5 '45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

08416

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Fruitland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred: Parsonage Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Fruitland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Parsonage Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Willie Anna Pusey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 10-1871

8. AGE: Years: 74 | Months: 7 | Days: 19 | If less than one day: hrs. min.

9. Birthplace: R.D. Eden Maryland (Town, county, and state)

10. Usual occupation:
11. Industry or business: at Home

FATHER
12. Name: Henry A. Pusey
13. Birthplace: R.D. Eden Md.

MOTHER
14. Maiden name: Lilly A. Stevens
15. Birthplace: R.D. Eden Md.

16. Informant: Mrs. Minnie H. Foster
Address: Parsonage St. Fruitland Md

17. Buried (Burial, cremation, or removal Which?) Date thereof Sept. 1-45 (month) (day) (year)
Cemetery or crematory: Fruitland Eden
Location: Fruitland Maryland

18. Funeral director: Hillman & Co. Walter R. Hillman
Address: Salisbury Md.

19. 9/1/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29th 45 at 12.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1945 to Aug 29 1945
and that I last saw h[illegible] alive on Aug 26 1945

Immediate cause of death	DURATION
cerebral hemorrhage	10 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D.
M. D. or other
Address: Salisbury Md. Date signed: Aug 31

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170)

CERTIFICATE OF DEATH

18417

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Worcester
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Near Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME John Ricks

3.(b) Social Security Number 189-09-5655

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife Emily Ricks
6.(c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55	—	—	... hrs. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Mill

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden name Unknown
15. Birthplace

18. Informant Emily Ricks
Address Pocomoke City R R # 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 24-1945 (month) (day) (year)
Cemetery or crematory St Frances Cemetery
Location Rural Pocomoke Md.
18. Funeral director Margaretta R Watson
Address Pocomoke Md.

19. 8/28/45 (Date rec'd by registrar) Lassie E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1945 at 6.05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Fracture Skull	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of Aug 18 45
Where did injury occur? Pocomoke City Worcester Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public highway
Means of injury Wheel came off truck Injured at work? No

23. SIGNATURE John L Riley Dep. Med Exam
M. D. or other
Address Snow Hill Md Date signed Aug 21 '45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

08418

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21a)

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:
County: Wicomico
City or town: Mardela Md R.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Mardela Md R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charley H. Robinson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Widowed

6.(b) Name of husband or wife: Rachel Robinson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Sept 12 1848

8. AGE:

Years	Months	Days	If less than one day
97	11	18	..... hrs. ..... min.

9. Birthplace: Wicomico Md (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:
FATHER 12. Name: Charles Robinson
13. Birthplace: Md
MOTHER 14. Maiden name: Unknown
15. Birthplace:
16. Informant: Bertha Bennett
Address: Mardela Md R.D
17. Burial (Burial, cremation, or removal? Which?) Date thereof 9. 1. 1945 (month) (day) (year)
Cemetery or crematory: Mardela
Location: Mardela Md
18. Funeral director: Graveson Bros
Address: Sharptown Md
19. 9/1/45 (Date rec'd by registrar) 19..... W. H. Robertson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30th 1945 at 6.30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25 1945, to August 28th 1945 and that I last saw h.. alive on August 29th 1945

Immediate cause of death	DURATION
arteriosclerosis	
Due to	
Due to	
Other conditions Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causee, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: William E. Nichols M. D. or other
Address: Helen Md Date signed Aug 30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0841?

★ Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? E S Tb Sanatorium
Hospital, Institution, or street address where death occurred:
5 mo 28 days
How long in hospital or institution? 5 mo 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Mardela Springs
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Florence Eva Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22, 1923

8. AGE: Years	Months	Days	If less than one day
21	8	15	hrs. min.

8. Birthplace Salisbury, Maryland
(Town, county, and state)
10. Usual occupation none
11. Industry or business

FATHER
12. Name Elija Emory Smith
13. Birthplace unknown

MOTHER
14. Maiden name Molly Figgs
15. Birthplace unknown

16. Informant deceased on admission
Address

17. Buried Date thereof Aug. 10-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Parsons Cemetery
Location Salisbury Maryland
18. Funeral director Holloway & Walter B. Holloway
Address Salisbury Maryland.

19. 8/10/45 [illegible] Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1945 19 at 6.45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/9/45 19 to 8/7/45 19 and that I last saw her alive on 8/7/45 19

Immediate cause of death	DURATION
(a) Pulmonary Tuberculosis	2 yr
Due to (b)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul Owen M.D.
M. D. or other
Address Salisbury Md. Date signed 8/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48

08420

CERTIFICATE OF DEATH

★ Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury Rural 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 years
Hospital, Institution, or street address where death occurred:
Anderson Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Wicomico
City or town Salisbury Rural 2
(If outside city or towe limits, write RURAL and give nearest town)
Street No. Anderson Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Gertrude Evelyn Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
Female	white	married

6.(b) Name of husband or wife Carl H. Smith
6.(c) If alive, give age 61 years
7. Birth date of deceased (mo., day, yr.) April 11, 1886

8. AGE: Years	Months	Days	If less than one day
59	4	13	hrs. min.

9. Birthplace Whitemlle, Sussex co. Del
(Town, county, and state)
10. Usual occupation at Home
11. Industry or business

FATHER
12. Name Benjamin L. S. White
13. Birthplace Sussex co Del

MOTHER
14. Maiden name Sarah C. Calloway
15. Birthplace Sussex co. ~~Del~~

16. Informant Mr Carl H. Smith
Address Salisbury, Md. R.D. 2
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/26/45 (month) (day) (year)
Cemetery or crematory Wicomico memorial Park
Location Salisbury, Md.
18. Funeral director The Hill & Johnson co
Address Salisbury, Md.
19. 8/26/1945 (Date rec'd by registrar) Elizabeth E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24, 1945, at 3 20 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19.. to Aug 24 1945
and that I last saw h.. alive on Aug 23 1945
Immediate cause of death Carcinoma Uteri — DURATION 1 yr
Due to Metastasis Lungs — 3 mo
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. R. Brownley M.D.
M. D. or other
Address Salisbury Md Date signed Aug 25 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

08421

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 years

Hospital, institution, or street address where death occurred: P. H. Hospt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 1306 N. Dunson St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lillie H. Turner

3. (b) Social Security Number

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Benjamin W. Turner

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): May 2 1878

8. AGE: Years 67 | Months 3 | Days 16 | If less than one day: hrs. min.

9. Birthplace: Willards Md. (Town, county, and state)

10. Usual occupation: Home Wife

11. Industry or business: at Home

FATHER 12. Name: Charles Bakes

FATHER 13. Birthplace: Worcester Co. Md

MOTHER 14. Maiden name: Louisiana Bethards

MOTHER 15. Birthplace: Willards Md.

16. Informant: Mr. Benj. W. Turner

Address: 1306 N. Div. St. Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug 20-45 (month) (day) (year)

Cemetery or crematory: Payne Mem.

Location: Salisbury Md

18. Funeral director: Fallon & Walston

Address: Salisbury Md.

19. 8/20 1945 Harriet E. Johnson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 18th 1945 at 3:59 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 45 to Aug 18 19 45 and that I last saw h[illegible] alive on Aug 18 19 45

Immediate cause of death	DURATION
Cachexia from	
Due to Generalized Carcinoma	
Due to Primary in breast. Cr. & Op.	
Duration: five years.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Russ G. Swain M. D. or other

Address: Salisbury Md Date signed: 8/20/45

Evidence for change of date of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08422

File No. G 98 SEP 18 1945

Reg. Dist. No. 337

1. PLACE OF DEATH:

County: Wicomico

City or town: (If outside city or town limits, write RURAL and give nearest town): White Haven

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: White Haven
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anthony C. Wainwright

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ~~December 22, 1945~~ Aug. 22, 1945

8. AGE: Years: 1 | Months: 8 | Days: | If less than one day: hrs. min.

9. Birthplace: White Haven (Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER — 12. Name: David Smith

13. Birthplace: Delmar Del.

MOTHER — 14. Maiden name: Reba Wainright

15. Birthplace: White Haven

16. Informant: Reba Wainright

Address: White Haven, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 27 1945 (month) (day) (year)

Cemetery or crematory: Clara Barton

Location: near Colored Parsonage

18. Funeral director: C. E. Messick

Address: Pittsville, Md

19. Aug 23 1945 (Date rec'd by registrar) L. Wolford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 22nd 1945 at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 1945 to Aug 22 1945 and that I last saw him alive on Aug 21 1945

Immediate cause of death	DURATION
Infantum, Diarrhea	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D Allen Twells M. D. or other

Address: Mountaire Md Date signed 8-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08423

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred: P. G. Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Pittsville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Glenn T. Waters

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 23, 1932

8. AGE: Years 13 | Months 2 | Days 30 | If less than one day ..... hrs. ..... min.

9. Birthplace: Pittsville, Wicomico, Md. (Town, county, and state)

10. Usual occupation: School Child

11. Industry or business:

FATHER — 12. Name: Robert Waters

13. Birthplace: Wanticoke, Md.

MOTHER — 14. Maiden name: Annie E. Barkley

15. Birthplace: Pittsville, Md.

18. Informant: Robert Waters

Address: Pittsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 26 1945 (month) (day) (year)

Cemetery or crematory: Pittsville Colored

Location: Near Waters Store

18. Funeral director: C. D. Pearson

Address: Berlin Md

19. 8/26/45 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 22 1945, at 11 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-13-45 19.. to 8/22 19.45

and that I last saw h[illegible] alive on 8/22/45 19..

Immediate cause of death	DURATION
Acute Uremia	12 hrs.
Due to: Nephritis	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Tonsils & Adenoids Aug 13, 45 Date of op. 8/13/45

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Miller R. Phillips M.D. M. D. or other

Address: Salisbury Md Date signed 8/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

CERTIFICATE OF DEATH

118424

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, Institution, or street address where death occurred:
Salisbury Rural 2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Gilbert Stanley White

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 10 1910

8. AGE: Years	Months	Days	If less than one day
34	8	24	..... hrs. ..... min.

9. Birthplace Wicomico co, Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Purnell D. White
13. Birthplace Wicomico co, Md

MOTHER
14. Maiden name Sallie V. Bounds
15. Birthplace Wicomico co, Md

16. Informant Woolford J. White
Address Salisbury Md. R.D.2

17. Burial Date thereof 8/5/45
(Burial, cremation, or removal) Which? (month) (day) (year)
Cemetery or crematory Bivalve Cemetery
Location Bivalve Md

18. Funeral director McHall & Johnson co
Address Salisbury Md

19. 8/6/45 Harriet E. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3, 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19..
and that I last saw ..... alive on ..... 19..

Immediate cause of death Coronary Thrombosis — DURATION: Sudden death

Due to .....

Due to .....

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings of operations None — Date of op. .....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE for Rademaker M. D.
Deputy Med Examiner
M. D. or other
Address Salisbury, Md Date signed 8/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

08425

★ Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred: Camden Court #3
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For nonresidents give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3 Camden Court
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Emma Alpheus White

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Alice Jane White
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Feb. 29-1860

8. AGE: Years: 85 | Months: 5 | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Wetzogum Md
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER
12. Name: James F. White
13. Birthplace: Wetzogum Md

MOTHER
14. Maiden name: Sarah A. Rencher
15. Birthplace: Wetzogum Md.

16. Informant: Mrs. Emma Davis
Address: #3. Camden Court. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug 5-1945 (month) (day) (year)
Cemetery or crematory: Turner Cem
Location: Nanticoke Md
18. Funeral director: C. Glenn Messick
Address: Berlin Maryland.

19. 8/15 19.45 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 2nd 1945 at 7a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 19 to Aug 2 1945
and that I last saw him alive on July 15 1945

Immediate cause of death	DURATION
Chronic myocarditis	3 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harry Mumma M.D.
M. D. or other
Address: Salisbury Md. Date signed: Aug 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

08426

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13a

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15-2 years
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: wicomico
City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 617 Parkside ave
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American

3. (a) FULL NAME Thomas P Wilson

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a-a	Married

6.(b) Name of husband or wife: Cassalena Wilson
6.(c) If alive, give age: Don't know years

7. Birth date of deceased (mo., day, yr.): about 1872

8. AGE: Years: 73 about | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Norfolk va (Town, county, and state)
10. Usual occupation: Spanish-American Veteran
11. Industry or business: Minister
FATHER 12. Name: Unknown
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Mrs Cassalena Wilson
Address: Salisbury md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 24 - 1945 (month) (day) (year)
Cemetery or crematory: Arlington va
Location: National Cemetery Near Washington D C
18. Funeral director: James H Stewart
Address: Salisbury md
19. 8/22/45 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 18, 1945, at 2 P M
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from May 23, 1945, to Aug 18, 1945
and that I last saw h[illegible] alive on Aug 6, 1945
Immediate cause of death: Acute Myocarditis — DURATION: 5 mos.
Due to: Chronic Nephritis — 2 years
Due to: Hypertension — 50 years
Other conditions: Arthritis — 6 mos.
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G H Lemmon M.D. M.D. or other
Address: Salisbury Md Date signed 8/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08427

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Not known
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? about two days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. no
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Walter Wodeon

3.(b) Social Security Number: Not known

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a-a	Single

6.(b) Name of husband or wife: no

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1903

8. AGE: Years	Months	Days	If less than one day
42 about			hrs. min.

9. Birthplace: Franklin va
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER
12. Name: Del Wodeon
13. Birthplace: Franklin va

MOTHER
14. Maiden name: Susie Lewis
15. Birthplace: Franklin va

16. Informant: Del Wodeon
Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 21-1945 (month) (day) (year)
Cemetery or crematory: Public
Location: Salisbury Md

18. Funeral director: James H. Stewart
Address: Salisbury Md

19. 8/21/45 (Date rec'd by registrar) Pharaoh E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/18/45, at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-10 19 45, to 8/18 19 45
and that I last saw h... alive on 8-18 19 45

Immediate cause of death: Cerebral Hemmorhage — DURATION: 2 days

Due to:

Due to:

Other conditions: acute appendicitis — 8 days

(Include pregnancy within 3 months of death)

Major findings of operations: acute appendicitis — Date of op. 8/10/45

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. A. Rademaker M.D.
Address: Salisbury, Md M. D. or other
Date signed: 8/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15